§ 58-50-80. Standard external review.

(a) Within 120 days after the date of receipt of a notice under G.S. 58-50-77, a covered person may file a request for an external review with the Commissioner.

(b) Upon receipt of a request for an external review under subsection (a) of this section, the Commissioner shall, within 10 business days, complete all of the following:

(1) Notify and send a copy of the request to the insurer that made the decision which is the subject of the request. The notice shall include a request for any information that the Commissioner requires to conduct the preliminary review under subdivision (2) of this subsection and require that the insurer deliver the requested information to the Commissioner within three business days of receipt of the notice.

(2) Conduct a preliminary review of the request to determine whether:

a. The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided.

b. The health care service that is the subject of the noncertification appeal decision or the second-level grievance review decision upholding a noncertification reasonably appears to be a covered service under the covered person's health benefit plan.

c. The covered person has exhausted the insurer's internal appeal and grievance processes under G.S. 58-50-61 and G.S. 58-50-62, unless the covered person is considered to have exhausted the insurer's internal appeal or grievance process under G.S. 58-50-79, or unless the insurer has waived its right to conduct an expedited review of the appeal decision.

d. The covered person has provided all the information and forms required by the Commissioner that are necessary to process an external review.

(3) Notify in writing the covered person and the covered person's provider who performed or requested the service whether the request is complete and whether the request has been accepted for external review. If the request is complete and accepted for external review, the notice shall include a copy of the information that the insurer provided to the Commissioner pursuant to subdivision (b)(1) of this section, and inform the covered person that the covered person may submit to the assigned independent review organization in writing, within seven days after the receipt of the notice, additional information and supporting documentation relevant to the initial denial for the organization to consider when conducting the external review. If the covered person chooses to send additional information to the assigned independent review organization, then the covered person shall at the same time and by the same means, send a copy of that information to the insurer. The Commissioner shall also notify the covered person in writing of the availability of assistance from Health Insurance Smart NC, including the telephone number and address of Health Insurance Smart NC.

(4) Notify the insurer in writing whether the request for external review has been accepted. If the request has been accepted, the notice shall direct the insurer or its designee utilization review organization to provide to the assigned organization and to the covered person or authorized representative

who made the request for external review on behalf of the covered person, within seven days of receipt of the notice, the documents and any information considered in making the noncertification appeal decision or the second-level grievance review decision.

(5) Assign the review to an independent review organization approved under G.S. 58-50-85. The assignment shall be made using an alphabetical list of the independent review organizations, systematically assigning reviews on a rotating basis to the next independent review organization on that list capable of performing the review to conduct the external review. After the last organization on the list has been assigned a review, the Commissioner shall return to the top of the list to continue assigning reviews.

(6) Forward to the review organization that was assigned by the Commissioner any documents that were received relating to the request for external review.

(c) If the finding of the preliminary review under subdivision (b)(2) of this section is that the request is not complete, the Commissioner shall request from the covered person the information or materials needed to make the request complete. The covered person shall furnish the Commissioner with the requested information or materials within 150 days after the date of the insurer's decision for which external review is requested.

(d) If the finding of the preliminary review under subdivision (b)(2) of this section is that the request is not accepted for external review, the Commissioner shall inform the covered person, the covered person's provider who performed or requested the service, and the insurer in writing of the reasons for its nonacceptance.

(e) Failure by the insurer or its designee utilization review organization to provide the documents and information within the time specified in this subsection shall not delay the conduct of the external review. However, if the insurer or its utilization review organization fails to provide the documents and information within the time specified in subdivision (b)(4) of this section, the assigned organization may terminate the external review and make a decision to reverse the noncertification appeal decision or the second-level grievance review decision. Within one business day of making the decision under this subsection, the organization shall notify the covered person, the insurer, and the Commissioner.

(f) If the covered person submits additional information to the Commissioner pursuant to subdivision (b)(3) of this section, the Commissioner shall forward the information to the assigned review organization within two business days of receiving it and shall forward a copy of the information to the insurer.

(g) Upon receipt of the information required to be forwarded under subsection (f) of this section, the insurer may reconsider its noncertification appeal decision or second-level grievance review decision that is the subject of the external review. Reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision under this subsection shall not delay or terminate the external review. The external review shall be terminated if the insurer decides, upon completion of its reconsideration, to reverse its noncertification appeal decision or second-level grievance review decision and provide coverage or payment for the requested health care service that is the subject of the noncertification appeal decision or second-level grievance review decision.

(h) Upon making the decision to reverse its noncertification appeal decision or second-level grievance review decision under subsection (g) of this section, the insurer shall notify the covered person, the organization, and the Commissioner in writing of its decision. The organization shall terminate the external review upon receipt of the notice from the insurer sent under this subsection.

(i) The assigned organization shall review all of the information and documents received under subsections (b) and (f) of this section that have been forwarded to the organization by the Commissioner and the insurer. In addition, the assigned review organization, to the extent the documents or information are available, shall consider the following in reaching a decision:

(1) The covered person's medical records.
(2) The attending health care provider's recommendation.
(3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.
(4) The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.
(5) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization.
(6) Medical necessity, as defined in G.S. 58-3-200(b).
(7) Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The assigned organization shall review the terms of coverage under the covered person's health benefit plan to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan with the insurer.

The assigned organization's determination shall be based on the covered person's medical condition at the time of the initial noncertification decision.

(j) Within 45 days after the date of receipt by the Commissioner of the request for external review, the assigned organization shall provide written notice of its decision to uphold or reverse the noncertification appeal decision or second-level grievance review decision to the covered person, the insurer, the covered person's provider who performed or requested the service, and the Commissioner. In reaching a decision, the assigned review organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or the insurer's internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

(k) The organization shall include in the notice sent under subsection (j) of this section:

(1) A general description of the reason for the request for external review.
(2) The date the organization received the assignment from the Commissioner to conduct the external review.
(3) The date the organization received information and documents submitted by the covered person and by the insurer.
(4) The date the external review was conducted.
(5) The date of its decision.
(6) The principal reason or reasons for its decision.
(7) The clinical rationale for its decision.
(8) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.
(9) The professional qualifications and licensure of the clinical peer reviewers.
(10) Notice to the covered person that he or she is not liable for the cost of the external review.

(l) Upon receipt of a notice of a decision under subsection (k) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer shall within three business days reverse the noncertification appeal decision or second-level grievance review decision that was the subject of the review and shall provide coverage or payment for the requested health care service or supply that was the subject of the

noncertification appeal decision or second-level grievance review decision. In the event the covered person is no longer enrolled in the health benefit plan when the insurer receives notice of a decision under subsection (k) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer that made the noncertification appeal decision or second-level grievance review decision shall be responsible under this section only for the costs of those services or supplies the covered person received or would have received prior to disenrollment if the service had not been denied when first requested.

(m) For the purposes of this section, a person is presumed to have received a written notice two days after the notice has been placed, first-class postage prepaid, in the United States mail addressed to the person. The presumption may be rebutted by sufficient evidence that the notice was received on another day or not received at all. (2001-446, s. 4.5; 2002-187, ss. 3.1, 3.2; 2003-105, s. 3; 2005-223, s. 10(a); 2009-382, ss. 26, 27; 2013-199, s. 18.)